International Nutrition Communication Service
(INCS)

WORKSHOP REPORT

FOR

HELEN KELLER INTERNATIONAL

(August 11 - 12, 1980)

(Recommendations for developing
a nutrition education strategy and capability within
Helen Keller International's Nutritional Blindness Prevention Department)

Edited by Ron Israel - Project Manager, INCS

Contributing Authors

Richard Burke - Indiana University
Marcia Griffiths, Richard Manoff, Marian Zeitlin - Manoff International
Lyra Srinivasan - Nonformal Education Consultant
Nancy Terrett - UNICEF, Indonesia

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1980

Submitted by
Education Development Center
55 Chapel Street, Newton, MA 02160
To United States Agency for International Development
Washington, DC

This report has been conducted under Contract A.I.D./DSAN-C-0209, Office of Nutrition, Development Support Bureau, Agency for International Development, Washington, DC

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NUTRITION EDUCATION WORKSHOP REPORT

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NUTRITION EDUCATION WORKSHOP REPORT

Introduction

This Report is the outcome of a two-day nutrition education workshop for the staff of Helen Keller International's Blindness Prevention Department. The workshop took place because of HKI's desire to put more emphasis on nutrition education as a means of coping with problems of vitamin A deficiency blindness (xerophthalmia) in developing countries. Its purpose was to help HKI develop a strategy for utilizing educational interventions to combat xerophthalmia.

Consultants to the workshop were provided by the International Nutrition Communication Service (see participant list on page 3) in the fields of nutrition education planning, mass media, training and community-based programs, nonformal education, and evaluation. HKI participants included its Blindness Prevention Department home office professional staff, two members from its Advisory Committee on Prevention Activities, and representatives from three countries with nutritional blindness prevention programs in which HKI is involved--Bangladesh, Indonesia, and the Philippines. In addition, the workshop was blessed with participant observers from UNICEF, USAID, and WHO.

The workshop Report is designed to be a planning aid for HKI. The Report is intended to help the Blindness Prevention Department prioritize its activities as it begins to build a nutrition education capability.

It also provides HKI with a technical frame of reference to four key areas of development communications: planning, the development of mass media campaigns, community training, and evaluation. The technical guidelines are tailored to HKI program development needs and are the result of small-group discussion at the workshop.

The Report is divided into the following three sections: I. Workshop Recommendations Summary; II Highlights of Workshop Proceedings; and III. Guidelines.

Ron Israel
Project Manager
International Nutrition
Communication Service

September, 1980

LIST OF PARTICIPANTS

HELEN KELLER INTERNATIONAL
NUTRITION EDUCATION WORKSHOP

August 1980

ANDERSEN, Jean	Development Consultants International/ Mass Media and Marketing
BAGCHI, Kaylan	WHO Consultant/Nutrition Education
BURKE, Richard	INCS Consultant/Communications
COSTELLO, John	HKI/Associate Director
GOSSELIN, Hélène	UNICEF/Information Officer
GRIFFITHS, Marcia	INCS Staff/Nutrition Education
ISRAEL, Ronald	INCS Staff/Workshop Coordinator
KOZUSKO, Ronald	HKI/Information Officer
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MANTRA, Ida Bangus	Ministry of Health, Indonesia/ Health Education
KHAN, Mohsin Ali	Save the Children, Asia Region/ Nutrition Education
McKIGNEY, John	AID/Office of Nutrition
NAGER, Donna	HKI Staff/Health Education
PETTISS, Susan	HKI Blindness Prevention/Director
SIMMONS, Jeannette	Harvard University/Health Education
SOLON, Mercedes	Philippines National Nutrition Center/ Deputy Executive Director
SOMMER, Alfred	HKI/ Medical Advisor
SRINIVASAN, Lyra	INCS Consultant/Nutrition Education
TERRERI, Nancy	INCS Consultant/Nutrition Education
TOUREAU, Serge	HKI, Haiti/Project Coordinator
ZEITLIN, Marian	INCS Consultant/Nutrition

NUTRITION EDUCATION WORKSHOP REPORT

I. Workshop Recommendations Summary

Emerging from the two-day meeting are a series of recommendations for the host agency--Helen Keller International. These recommendations address the major questions: (1) What educational interventions are most appropriate for HKI to support in developing countriesù (2) What role can HKI play in developing nutrition education programs aimed at preventing xerophthalmia?

What follows is a summary of the major recommendations relative to each question.

1. Program Priorities

a) HKI should familiarize itself with each country's overall nutrition education needs and resources before deciding on a course of action. What is appropriate for one situation may not be appropriate for another.

b) Whenever possible, HKI should encourage and support nutrition education activities that seek to prevent xerophthalmia (as opposed to preventing blindness).

c) Priority target groups for xerophthalmia prevention programs are mothers and village-level field workers. HKI should encourage and support village-level activities and the design of community-oriented educational materials.

d) HKI should encourage and support the inclusion of xerophthalmia-prevention modules in the training curricula and materials for village-level health workers.

e) HKI should encourage and support programs that teach communication skills and participatory techniques to village-level health workers.

f) HKI should encourage and support programs that involve direct participation by mothers in diagnosing problems and designing programmatic solutions. Towards this end, support should also be given to programs that train field workers to be better communicators and facilitators of target group participation.

g) HKI should encourage and support the development of prototype materials and communications protocols geared toward village-level xerophthalmia prevention projects.

h) Demonstration education programs should also be given priority support and encouragement; i.e., teaching mothers how to grow, use, and prepare vitamin A-rich foods.

i) Where possible, HKI should support efforts that integrate vitamin A-specific messages into broader nutritional and/or health themes. For example, HKI materials and messages should stress the relationship between vitamin A and eye health in addition to admonitions to "eat green, leafy vegetables."

j) HKI should encourage the use of mass media to support (1) village-level xerophthalmia prevention activities; and (2) vitamin A capsule distribution campaigns.

k) Feeding habit studies should be encouraged and supported to understand local beliefs and practices vis-à-vis food and health.

l) HKI should consider developing program strategies that sensitize policy makers to the need to invest in xerophthalmia blindness prevention activities, particularly in Africa, where the official level of awareness is low relative to other areas of the Third World.

m) HKI should serve as a clearinghouse for technical information about vitam A and xerophthalmia and for nutrition education materials aimed at preventing xerophthalmia and nutritional blindness.

n) HKI should produce update sheets with vitamin A information as a vehicle for presenting program managers with ideas and new research findings for use in existing programs. One way of disseminating the information would be through regional or country medical journals.

o) More in-depth evaluation is needed to assess the effectiveness of HKI prototype materials in the context of in-country training programs.

p) Strategies should be developed to help countries produce local adaptations of existing HKI prototype materials.

2. Agency Role

a) HKI should expand its role in providing technical assistance and resource support to include nutrition education activities.

b) HKI should be prepared to weigh the pros and cons of investment in various nutrition education activities, and to determine the most appropriate nutrition education intervention(s) when considering alternative strategies to combat nutritional blindness and prevent xerophthalmia in a given country.

c) HKI should develop a capability to provide technical assistance to help countries plan, implement, and evaluate nutrition education programs aimed at preventing xerophthalmia.

d) HKI staff should have available resources to apply the full gamut of development communication processes to an analysis of a given country's nutrition education needs.

e) An HKI planning and technical assistance capability should initially be focused on village-level training and community-based programs.

f) In the short term, HKI should identify consultants, or a

supporting institution, to help develop projects aimed at preventing xerophthalmia and targeted towards village-level health workers and mothers. Specific areas of expertise include mass media, nonformal education and training, learner-centered programs, and formative evaluation.

g) In the long term, HKI should increase its home office nutrition capabilities through either (a) hiring an additional education/communication specialist, or (2) training existing staff in nutrition education planning.

h) HKI should provide training for its country program staff in nutrition education planning and development communications techniques.

i) HKI should develop a statement of its nutrition education priorities and capabilities that can be disseminated to its clientele in developing countries.

j) Currently, the most appropriate place for HKI to explore interest in the development of village-level nutrition education activity would be Indonesia. Indonesia has a well-established village-level health/nutrition program and has just conducted a vitamin A prevalence survey which concluded that feeding habits and beliefs were at the core of the nutritional blindness problem.

k) In Bangladesh, HKI might explore with UNICEF and the Ministry of Health the possibility of developing a mass media campaign in conjunction with the ongoing capsule distribution program.

l) In the Philippines, HKI might promote activities that seek to integrate more thoroughly xerophthalmia prevention messages and materials into the ongoing programs of the Philippine National Nutrition Program.

m) In Haiti, HKI might help sponsor a general nutrition education needs assessment to determine the most appropriate educational

intervention(s) to reach high-risk nutritional blindness target groups.

n) HKI should develop a proposal, and seek sources of funding, for a Vitamin A Clearinghouse that would disseminate technical information and "exemplary" educational materials about vitamin A xerophthalmia.

II. Highlights of Workshop Proceedings

(This section is devoted to highlights of the three "General Sessions" of the workshop. Much of the rationale for the recommendations in Section I can be found in the transcription of the discussions that follows.)

August 11: Morning Session

1) Introduction given by Dr. Pettiss

Dr. Pettiss stressed the agency's commitment to working on the educational aspects of nutritional blindness prevention and expressed a desire to consider the options available in pursuing this course of action. Dr. Pettiss also mentioned the special meeting in October in Jakarta on vitamin A and said that she hoped that the recommendations coming from the workshop could be shared at this October meeting.

2) Summary of a Background Paper developed for the workshop by INCS (copies available upon request from Helen Keller International or Education Development Center)

3) Historical perspective on the training materials developed, 1975-1977

Dr. Simmons spoke about the development of materials which fill the need for training and information for different types of people (from policy makers to field workers) concerning vitamin A deficiency, its consequences, detection, and the possible interventions which would alleviate and/or prevent the deficiency. Dr. Pettiss explained that special emphasis had been placed on top-level policy makers whose support is crucial to any program.

In areas where HKI has been involved, the materials have served to support other training activities. However, where HKI has not had a program, the materials have been "freestanding." Because they were developed as prototypes, they are distributed with letters which encourage the recipients to adapt the materials. However, little work has resulted in the adaptation of the materials to country-specific situations. HKI has even had to undertake the translation of the different materials.

Question raised by Dr. Pettiss: Should HKI produce village-level

materials? And if so, how? An explanation was given concerning the strategy behind the materials already produced. The strategy was primarily aimed at building the awareness of policy makers and physicians concerning the problem of xerophthalmia and what could be done. It was a preventative strategy, in medical terms, of early detection and administration of the capsule to keep the eye disease from progressing. In almost every case, the materials were linked to a program of capsule distribution, which has been the most popular intervention for the prevention of nutritional blindness. However, it was made clear that the link with a capsule distribution program may not necessarily be as important in the future, and that good materials, which deal with the problem in a more community-centered way, need to be developed for village-level field workers and for mothers.

Dr. Bagchi summarized the target groups for HKI nutrition education activities: (1) policy makers; (2) senior health workers and administrators; (3) peripheral health workers; (4) mothers. The future strategy should focus on groups 3 and 4, where the problems can be directly combated. Also, an integrated approach with general nutrition education should be contemplated.

In light of the emphasis on the education of the village-level health worker and the mother, Mr. Manoff suggested a reorganization of the strategy. He recommended moving away from the present strategy, which is directed at detecting signs of disease, because it focuses awareness on the disease only after it is present. The concern for the problem needs to be developed much earlier and prevented entirely. The change in emphasis should be a consideration where message content is concerned. The messages should be made less technical and more relevant to the needs of field workers and mothers. In response to this, Dr. Pettiss raised the question of whether HKI is preventing blindness or xerophthalmia? There was general agreement that the past strategy was blindness prevention and that the future strategy will be prevention of xerophthalmia.

However, it was mentioned by Ms. Terreri that the situations

may differ between countries and that each country in which HKI works should be "assessed" for its readiness for different strategies. If the decision makers need more convincing, then more materials should be developed for them, as well as additional materials for physicians, before focusing on community workers.

4) Presentation by Ms. Leone of Slide Set #103, for the orientation of village-level workers, and discussion of #102, the four-page leaflet with pictures of the different stages of xerophthalmia

The #102 is the most widely distributed Helen Keller material; it has been used alone and been inserted into health manuals in different countries. More emphasis could be given to the depiction of night blindness with local adaptation of the description of the state.

- Both slide sets are accompanied by a "how to use" explanation.
- No outside evaluation has been done of the training with the slides.
- There is a need for local characteristics to be considered and incorporated in the material. Foods for children, especially the green, leafy vegetables, should be those available to rural families, not just those available within the countries.
- There is a need for motivational background material to involve each different target audience in nutritional blindness prevention activities. This material should include specific suggestions for what can be done to utilize target group skills.

5) Country presentations

A) Indonesia: Dr. Mantra began by mentioning that vitamin A deficiency is one of the four major nutrition problems in Indonesia, and that the government, in cooperation with AID and HKI, has just completed an in-depth study of the problem. The results of this study are now available. Dr. Mantra then presented an outline of the health infra-structure in Indonesia, pointing out the cooperative effort which currently exists between many sectors of Indonesian society to bring about nutrition improvement. He mentioned that in nutrition program matters, the Directorate of Nutrition decides technical issues, while the Directorate of Health

Education is responsible for all nutrition education. For operational aspects of programs, the health center is the key to any successful program. Dr. Mantra also explained that there are two educational approaches:

(1) For the Providers: They are shown the existing problem and asked how they will solve it. The expertise for solving the problem is then taught.

(2) For the Community: The emphasis is on developing the potential of the community to solve its own problems, based on participation and self-reliance.

In terms of the development of educational materials, Dr. Mantra described his program, which uses a formative evaluation approach to assessing community needs, after which behavior-specific messages are developed. Following message and materials development, the community members are again consulted to be sure that they can carry out the specific behavioral recommendation and can understand the presentation of the material. In this campaign vitamin A messages are included in the general nutrition messages for the different ages of children. The materials developed to date are radio spots and action posters.

Dr. Mantra raised the question: Can educational materials present only recommendations to consume green leafy vegetables, or should the relationship between vitamin A and eye health be explicitly stated?

Adding to the Indonesia report, Dr. Sommer commented on some of the results of the recently completed survey on xerophthalmia:

- 75% of the children with xerophthalmia consume MSG, a seasoning that is being considered for fortification.
- 90% of the homes with children with xerophthalmia have family members who consume green leafy vegetables regularly.
- The survey identified several important dietary solutions for the prevention of vitamin A deficiency:

  (a) Children zero to two years of age: breast feeding;
  (b) Children one to three years of age: vitamin A-rich fruits;
  (c) Children above two years of age: green leafy vegetables.

- There are two problems related to including more vitamin A-rich foods in the diets of young children: (a) mothers of children under the age of two don't know how to cook the leaves; and (b) mothers of children over the age of two report that their children don't like the vegetables.

August 11: Afternoon Session

B) Bangladesh: Mr. Khan related the vitamin A activities within the Save the Children project in Bangladesh, where vitamin A capsules are being distributed to all children between six months and six years of age. He also mentioned some of his experiences in community education concerning vitamin A:

- Mothers are not aware of night blindness.
- Mothers do not perceive the risks of health problems as health professionals do.
- Mothers say that green vegetables cause diarrhea.
- Working with rural people's perceptions is the challenge. Mr. Khan related the story of the man who did not cry over the death of his son, but cried when his cow died because, although he can always produce another child, he can't produce, but must buy, another cow.

Dr. Pettiss explained the Bangladesh National Blindness Prevention Program to which HKI offers technical assistance. Emphasis is on a large-scale capsule distribution program, which is funded almost exclusively by UNICEF. HKI has a representative in Bangladesh to help with monitoring the capsule distribution program and with the higher priority nutrition education efforts. An advantage, or disadvantage, of the situation in Bangladesh is that there are two nutrition institutes which are often in competition.

Every six months the national program distributes vitamin A capsules to children under six years of age through the Family Welfare Workers (FWW's), who work out of rural health centers. One problem is that there is pressure to give the capsule to those not included in the priority group, thereby encountering the risk of vitamin A toxicity. Also, there is the danger that rural people might feel that if they can correct the problem with a pill, they do not have to bother with eating green leafy vegetables.

The nutrition education materials developed in Bangladesh include: a film on vitamin A deficiency to be shown in movie theaters; a flip-chart adapted from the Haiti prototype; a poster; and the 102 material from HKI, which is in Bengali and has been distributed to FWW's.

No comprehensive education strategy has been outlined in Bangladesh for the prevention of nutritional blindness.

C) Philippines: Mrs. Solon presented the nutrition activities in the Philippines which relate to the prevention of nutritional blindness. The Philippines uses the HKI slide sets in training--primarily of village-level field workers. However, the new emphasis in this training is on communication skills and on translating technical knowledge to action-oriented village programs. The National Nutrition Program is a partnership between the public and private sectors which extends from the national to the village level, where local governmental bodies are encouraged to formulate, as well as fund, nutrition programs. From those programs directly related to vitamin A, there are three different interventions being tried:

- Capsule distribution: the question is of which delivery system is best--at present, school teachers and field workers have been chosen to distribute the capsules.
- Fortification: programs have fortified MSG in two provinces.
- Nutrition education: the emphasis is now on the peripheral workers, for whom an attempt is being made to standardize training materials, both in print and video; and the mothers, to engage them in participatory programs.

The video tape of the Philippine Nutrition Program was shown. The discussion returned to the issue of support and supervision of the village-level nutrition worker. Mrs. Solon related the experiences the program has had with video and the nutri-buses as a support system for the Barangay Nutrition Scholars (BNS). The effectiveness of the video tape when used with the BNS and a communicator with one day of communications training proved to be three times that of other methods, using the sale of Nutripak as a measure. They are currently working on a standardization of physical signs which could be used in place of weight gain for judging improvement in nutritional status. The overall success of the program will be measured by the ability of the mothers to make the supplemental food themselves with foods locally available.

D) Haiti: From 1974-75 a prevalence survey was done. In 1976 a program of capsule distribution, training of health workers, and nutrition education was instituted. A flip-chart, dramatizing the problem

of xerophthalmia, was developed for all field workers distributing capsules. People working in Haiti have developed posters and radio spots. One of the most effective factors in the Haitian program has been the project director, Serge Toureau, who has been very dynamic in delivering the message of the importance of vitamin A to groups within Haiti, as well as to representatives from other nations.

* * * *

The workshop then divided into four small groups to work on developing "technical guidelines" about basic communications for HKI. The four groups focused on the areas of message design, mass media campaigns, training and community-based programs, and evaluation. Small-group work occupied the August 11th afternoon and August 12th morning sessions of the workshop.

August 12: Afternoon Session

6) Comments from observers

A) Dr. McKigney, from AID, expressed the agency's interest in nutrition education and said that he was glad to seek HKI taking this initiative. He also spoke of the collaboration between AID and WHO on the vitamin A problem, and of the formation in 1974 of the International Vitamin A Consultative Group (IVACG), which brings people together to exchange information and to develop guidelines in the area of vitamin A programs. There have been seven task force reports issued by IVACG. The topic of the last report, No. 7, which is shortly to be released, is the safe use of vitamin A. IVACG will also be a co-sponsor of the WHO vitamin A conference to be held in mid-October in Jakarta. This will be a meeting to bring participants up to date and to discuss the implications of the programs which have been active in Asia, primarily in the Philippines and Indonesia. IVACG has funding through 1982.

Dr. McKigney also expressed his disappointment that to date no Near Eastern or African government has chosen to participate in IVACG. Presently, WHO, with AID funding, is conducting prevalence explorations of vitamin A deficiency in 19 countries in these regions. Dr. McKigney

suggested that if any of these countries begin programs, there will be new educational challenges both in formulating content and strategy.

Dr. McKigney also mentioned that AID is currently signing a cooperative agreement with the International Center for Epidemiologic and Preventive Ophthalmology at Johns Hopkins. The director of the center is Dr. Alfred Sommers. This agreement will allow AID to offer assistance immediately to countries requesting help and even, in some instances of need, to take the initiative.

Dr. McKigney said that it may be important to work more with IVACG in the area of education. Perhaps in the next year IVACG would be interested in addressing the issue at a meeting.

B) Ms. Gosselin, a UNICEF information officer, discussed the renewed interest of UNICEF in childhood disabilities, which includes blindness. The emphasis of the program will be on the reintegration of the disabled into community life. UNICEF is preparing a film, an educational kit, and other materials for this program.

Dr. Pettiss mentioned the excellent collaboration which exists between HKI and UNICEF. UNICEF has purchased the 103 from HKI in quantity for training village-level workers, and has given money for the development of materials in specific countries.

7) Discussion of education strategies or directions for HKI in relation to the identified target groups

A) Policy makers: Mr. Israel posed the question of how HKI could improve its efforts to convince policy makers to invest money in these programs. Dr. Mantra suggested that, although Indonesia does not have this problem, there is a problem with coordination between sectors, which causes money to be diverted to many smaller projects rather than being concentrated in one project which would have greater impact.

Ms. Terreri raised the point that HKI could consider working with groups other than the Ministry of Health alone, depending on which programs were particularly strong in a given country.

Mrs. Solon thought it important to appeal to the hearts as

well as the minds of policy makers. She suggested that policy makers at all administrative levels be included, because often it is easier to appropriate money and to implement programs on a local level than on a national level. Also she suggested that, for successful programs and a truly cooperative effort, the program implementers should free themselves from loyalties to particular funding sources.

Mr. Israel suggested that not all policy makers may be as convinced as those in Indonesia and the Philippines. Particularly in Africa, the consent of policy makers may still be difficult to obtain. Dr. Sommers pointed out that convincing African policy makers may present new challenges since they view xerophthalmia as "measles blindness," so that concern is focused on the measles rather than the vitamin A deficiency.

B) Dr. Bagchi, from WHO, stressed in his remarks the need for HKI to concentrate future efforts on training and education of peripheral health workers and on examining how they operate in target group communities. Dr. Bagchi mentioned several areas in which HKI and WHO could cooperate:

(1) in the "total" training of the peripheral health care worker--not just in blindness prevention;

(2) in elaborating new strategies in nutrition education that take into account existing situations in the countries where assistance is offered--strategies that will ensure that education reaches the community level.

Mrs. Solon added that it is important to integrate vitamin A into existing training and nutrition education programs in order to overcome the resistance which is developing to new programs which require more reports and focus the attention on the top levels of these programs, rather than on the communities. It was recommended that more village-level health planning should take place.

Mr. Israel proposed that an important first step for HKI in any country would be to assess existing programs and resources to see where vitamin A information and intervention strategies could most successfully be integrated.

Dr. Zeitlin recommended update sheets with vitamin A information,

which could be used as a vehicle for presenting program managers with ideas and new research findings for use in existing programs, rather than being presented as a new program.

Dr. McKigney said that this was in line with the recommendations of the IVACG report of Task Force VI, in which they stress the interrelationship of vitamin A deficiency with general nutrition status. The challenge is to explain this interrelationship to field workers and mothers. More discussion took place on the idea of HKI distributing the update sheets. Dr. Pettiss indicated that this would be feasible, using the HKI roster, and that it may be particularly important to do after the meetings in Jakarta. She also thought that it might be appropriate to report some of the information from the Indonesia study.

Dr. Sommer proposed that the information sheet be drafted before the Jakarta meeting so that it could be distributed to the country representatives at the meeting, with instructions to distribute it in their respective countries when they returned. Also put forward was the idea to publish the information in the medical journals of different countries.

The need for developing a distribution system as part of an overall strategy was recognized as a matter which should be addressed.

Additionally, Ms. Srinivasan raised the question of how to balance the need for documentation and information about knowledge, attitudes, and practices, on the one hand, with programs at the village level and their perennial problems of work overload for program implementers and field workers, on the other. This remained an open question.

C) Ms. Srinivasan began a discussion about how to reach mothers by suggesting that training for field workers should include an option to the didactic approach. The alternative could be more direct participation--to examine the motivation and sense of responsibility of the workers, mothers, and the community when they are given a more direct role in diagnosing their problems and taking action. Initially, small projects could be undertaken. For example, the flip-chart could be designed with specific stopping points--where questions could be inserted. Instead of being bound, the pages could be loose to allow for more flexibility in their use.

The flip-chart could be packaged for both a traditional and a more open-ended approach.

Additionally, Ms. Andersen suggested that one day of training in two-way communication may be useful. The training would include how to ask open-ended questions tailored to specific behavioral objectives, how to listen, how to draw people out, how to reinforce rather than punish.

Ms. Leone said that this approach may be difficult to implement when working only at a central level with the trainers of trainers. Ms. Anderson suggested that one approach would be to push for the development of materials which control both the content and the process. The video tape has this function in the Philippines; however, there may be other ways. The comment was added that the asking of questions is often language-related and that HKI should participate in adapting any prototype materials to local language when an open-ended question process is involved. Additionally, it was emphasized that if open-ended questions are going to be used, field workers or other educators must learn to listen.

Dr. Burke recommended that the training in two-way communication might also include interview techniques so that these same people could collect information for evaluation purposes.

Ms. Terreri stressed the use of participatory methods in education at the community level and the need for HKI to explore carefully the usefulness of these techniques. HKI could work with a private agency on a small scale, comparing more didactic materials to those adapted for the participatory approach. HKI could also generate ideas and samples of different teaching methodologies using the subject of vitamin A (e.g., role-playing about night blindness).

Dr. Zeitlin suggested that HKI might have a role in developing xerophthalmia prevention training modules for community-level workers.

8) Mr. Israel expressed the hope that one thing the workshop had done was to help HKI see the options available for educational interventions, and have the ability to assess what activities are appropriate given differing circumstances among countries; that the workshop might

have made the HKI staff more comfortable in the role of nutrition education planners.

Ms. Leone said that she felt more comfortable about helping to identify priority steps, given a country's situation, and to help them plan how to carry out each step.

Dr. Pettiss reiterated this, and added that she was glad to know where she could go for expert help, both in countries which may be neighbors to future project countries, and in the United States. She suggested that HKI might be able to help an exchange of information in the future between countries with vitamin A nutrition education programs.

The discussion at this point was open to questions from HKI.

Dr. Pettiss asked if it is valid for a narrowly focused agency, such as HKI, to concentrate its educational efforts so narrowly--on vitamin A--rather than more broadly, to encompass all of nutrition.

Dr. Zeitlin responded by saying that if the nutrition education infrastructure exists, it is easy to integrate vitamin A messages into the program. However, when the infrastructure does not exist, or is ineffective, what should HKI choose?

Mr. Manoff suggested that HKI should have a strategy prepared, when it is invited to a country, which would include: (1) the identification of existing working communication channels; and (2) the application of the entire development communications process--from audience testing to tracking studies--to the integration of vitamin A messages into existing efforts in nutrition education. He stressed that the strategy should not compete with or repeat other efforts, but should integrate its efforts with the infrastructure. HKI could offer staff services to existing line organizations to help develop a well-rounded nutrition education strategy which uses the different methods discussed in the workshop with vitamin A information integrated into each approach. There is always the obligation to examine all of the possibilities, even though each may not be pursued for lack of time, money, or manpower. The important element for HKI seems to be to know the "map" of nutrition communications.

Dr. Pettiss summarized the HKI staff's feelings after the workshop by saying that it had been a demystification process--that they had gained confidence during the two days, felt that they knew more than they thought, and were ready to move ahead. HKI will make it known that they now have something to offer countries and are better prepared to deal with nutrition education as an intervention. This has implications for staff and consultant resources, as well as for financial resources in the ability to fund materials development, if this is necessary. The question was raised by Dr. Pettiss about the initiative which HKI should take in disseminating materials, especially through groups like UNICEF, WHO, etc.

Dr. Simmons suggested that in light of what had been discussed, HKI might review program guides and project evaluations, selecting information relevant to a thrust toward materials development for village workers and mothers. Additionally, she recommended that some of the communication processes discussed for use in the community might be examined for their relevance when working with professionals.

The workshop was closed by Mr. Israel, who promised a report and expressed interest in future HKI program developments in nutrition education.

III. Technical Guidelines

This section focuses on providing Helen Keller International with suggestions for incorporating basic development communications processes into their proposed nutrition education programs. The section summarizes the results of four small-group sessions at the Workshop devoted to nutrition education planning, designing a mass media campaign, community training, and evaluation. It opens with a diagram, devised by Dr. Richard Burke, that describes for workshop participants the interrelationship of various parts of development communications theory.

A SLIGHTLY MORE SYSTEMATIC WAY OF LOOKING AT A COMPLICATED COMMUNICATION PROCESS

by

Dr. Richard Burke
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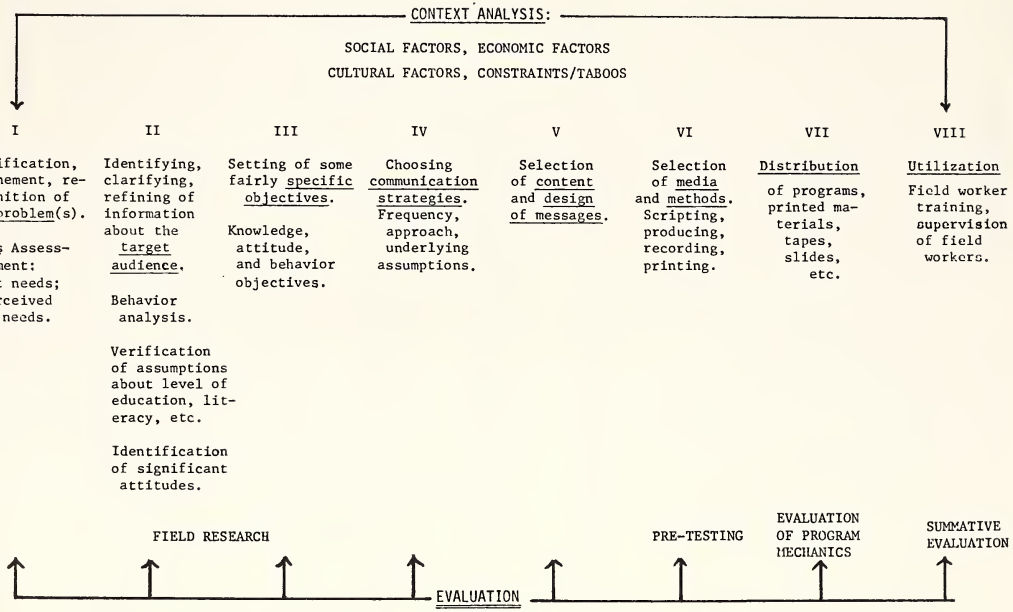

(a) Nutrition Education Planning

Group Leaders: Marcia Griffiths, Dr. Marian Zeitlin } Manoff International

A crucial first step in preparation for developing a national nutrition education strategy is the gathering of information specific to the participating (country(ies). This "country profile" would serve as a basis for strategy planning, for discussion of educational options based on actual needs. HKI could provide guidance in this initial stage by helping planners identify relevant behavioral and educational problems, and assessing the most appropriate channels of communication. HKI could begin by outlining the information gathering process.

1. At the national level

   - Specifying and ranking national nutrition and education priorities.
   - Reviewing existing information about nutrition and feeding practices which provide clues to behaviors affecting vitamin A status.
   - Examining the success of educational interventions used in the past, currently under way, or of those contemplated for the future.

2. At a state or provincial level--field offices, health centers, etc.

   - Reviewing the existing communications infrastructure--how do program messages reach the intended audience?
   - Discussing behaviors which the primary health care field staff sees as problems or resistance points to improving vitamin A/nutritional status.
   - Discussing field staff's perceptions of current and contemplated educational interventions.
   - Reviewing plans and instruments for use in a village information-gathering exercise.

3. At a village level, focus groups of about five village mothers with small children who could be canvassed to

   - Discuss behavioral resistance points identified earlier.
   - Uncover additional problem areas (information from these sessions can be used in later investigations at the village/household level).
   - Conduct dietary recalls for common vitamin A-rich foods.
   - Conduct group demonstrations--for example, weaning foods high in vitamin A, or particular gardening practices. These would be done to obtain initial reactions to possible recommendations.

In addition to the development of country profiles, HKI could assist countries with some of the specifics necessary to refine an overall strategy in behavioral terms. For example, HKI could

- Develop suggested approaches for investigating feeding habits and behaviors with limited manpower and financial resources; e.g.
  - through a small-scale survey done as a separate effort using social scientists or existing nutrition personnel;
  - through village-level workers. This would become a part of their training, learning to ask open-ended questions and to listen carefully to responses, abstracting from the responses things particularly relevant to message design;
  - through the epidemiologic study conducted, usually with HKI collaboration, at the outset of any vitamin A intervention.
- Develop a prototype "question guide" for investigators which would enumerate all of the behavioral and attitudinal factors which could prove important in changing vitamin A status.

(b) Designing a Mass Media Campaign

Group Leader: Richard Manoff, Manoff International

At the start of the session, emphasis was placed on the relationship of the mass media and mass communications in general to all the other aspects of nutrition education intervention. This was stressed for the reason that though the panel's discussion was being held separately, the mass media component could not be viewed as a thing apart from all other inputs that have to do with nutrition education.

This has particular significance when mass media are examined for their potential as a nutrition intervention. For example, the mass media perform a vital function in extending the reach of all other educational efforts because the mass media are not limited by the number of health workers or other personnel involved. Thus, the mass media function as a kind of automation of education, providing a means whereby the nutrition education messages can be distributed beyond the capability of personnel to do so on a direct contact basis.

Further, the mass media are ideal for self-limiting health problems in the sense that the mass media cannot adequately deliver messages of great elaboration or requiring discussion. But, fortunately, most of what we have to deal with in terms of critical nutrition problems are matters whose objective is behavior change in the individual which presumes the capability of the individual to solve the problem for himself or herself. Such self-limiting health problems and solutions are ideal for the mass media and help, therefore, to promote self-help and self-reliance in the target audience.

Still further, the mass media can provide a reach beyond the target audience to those secondary and tertiary target audiences so important to the success of nutrition education programs. Here we are speaking of government officials, policy makers, and the like--all of whom are in the audience of the mass media even though the messages may not be directly beamed at them. Nevertheless, in "talking over the shoulders of the target audience with which we are concerned" to the

secondary and tertiary target audiences, we are accomplishing other objectives in addition to our primary objective of achieving behavioral change.

It becomes essential to identify the mass media. The telephone, for example, is not a mass medium in the sense that it provides the capability of a one-to-one conversation. But, on the other hand, mass media like radio, television, cinema, billboards (hoardings), newspapers, magazines, the mail are mass media in that a message delivered by any one of them is theoretically capable of being delivered to vast audiences and most of them at just about the same time. Of course, the human being is another medium, but unless he or she is mobilized into an army of thousands, a person is obviously not a mass medium.

It is important to make this distinction and, in addition, to distinguish between media and materials. A film, for example, is a material, not a medium. It requires a medium for its delivery. Thus, a medium is a channel, a delivery system. A comic book is not a medium. It is a material. It requires some kind of delivery system to get into the hands of those of the members of the target audience for which it was designed. The same is true actually of a magazine or a newspaper, which require a delivery system to get them into the hands of intended readers.

The advantages of the mass media are that:

1. They provide us with the opportunity for a consistent message to all people at the same time.

2. They provide us with an opportunity to repeat the message consistently over time.

3. They provide us with an opportunity to talk "over the shoulder" to secondary and tertiary target audiences.

4. They are an organizing instrument in the sense that they can keep all people involved in the effort--regardless of which aspect--faithful to the objective and to the central message.

5. They help to institutionalize ideas by exposing them to all people in a public/social way.

The key question is the question of access and how one, for example, gets access to the airwaves of radio and television or into the pages of newspapers and magazines. Here we are generally dealing with a policy question--the public policy issue, for example, as to the responsibility of a government to make the airwaves of radio and television available for educational purposes. This is a matter that requires the politicization of nutrition educators in behalf of necessary public policy to make nutrition education possible through the most efficient of the mass media.

In the case of avitaminotic blindness, the use of mass media would require the development of an appropriate strategy. The mass media provide the opportunity of a preventive strategy in alerting mothers to the deficiencies that cause this disease and instructing them on how to prevent it. This does not mean that the mass media cannot also be used to help to identify and propose a treatment of those cases of the disease that already exist. But the fact is that the mass media, because of their nature, can enable us to go far beyond merely a therapeutic strategy into a health education strategy emphasizing prevention.

How to begin the design of a mass media campaign. The initial responsibility is to identify the problem and all its aspects. This requires research: formative evaluation and a baseline survey. Nor is it enough merely to identify the problem and also to identify it in its subtleties and all its facets for the reason that we will later be dealing with message design in which these various facets, constraints, resistance points must be dealt with. We must also identify the target audience in terms of the problem and again identify that audience, not merely in terms of superficial demographic information, but also in terms of religious practices, taboos, cultural concerns, etc. Again, these elements are important in the design of messages.

Once we have identified through research what we have to know about the problem, how it is perceived by our target audience, and have defined that target audience, we are then ready for message design. What goes into the message are essentially the answers to such questions as:

1. What is it they ought to know?
2. What is it they ought to do?
3. Why should they do it?
4. What good will come of it?
5. What bad if they don't?
6. Are they able to do this?
7. And how do we know it's right?

The answer to the last question can only be effectively answered through appropriate testing of our messages, which means in the case of radio, for example, actually recording the messages on cassettes and taking them out to be played for sample groups of our target audience together with a well-designed questionnaire that seeks to obtain audience response to every element of our message: content, information, clarity, comprehension, motivation, production values (music, voices, characters), etc.

The designing of a message is a highly-disciplined science coupled with the flair and color of an art. Community participation in the design of the message must be guaranteed at least by means of the research and of testing and retesting, if necessary.

Once our messages have been designed and tested, then we are ready to design our media strategy. The questions we must answer are:

1. How to deliver the message? (This is reach.)

2. How do we deliver the message frequently? (This is frequency.)

This combination of reach and frequency are the twin objectives of our media strategy in terms of our target audience. Media strategies must be designed on the basis of disciplines that instruct us to identify the most effective means of reaching the members of our target audience. In a multimedia campaign, the most effective combination of media is determined by the manner in which they reinforce and supplement each other in order to enhance our reach-and-frequency objectives.

We must pay particular attention to the difference in formats. A 15-minute or half-hour program on radio may be totally inappropriate, ineffective, and even wasteful if the message does not require such a lengthy single block of time. Ideally, to reach a maximum audience with frequency, the short message may turn out to be the most efficient in terms of our subject. This enables us to design a message perhaps one minute in length which could then be placed among popular programs in order to ensnare our target audience (largely unmotivated) at a time when they are watching entertainment of their choice. And because it is a short message, we can do this with some frequency on all the days of the week.

On the other hand, a one-time program is generally restricted to only once a day and more likely once a week, cutting down on the size of the audience as well as the frequency. Furthermore, programs generally tend to attract the already motivated, who are not among the core members of our target audience. These determinations rely on media data to the extent that they exist. Such data may cover the ratings of programs, the composition of audiences, the share of market enjoyed by competitive radio and television stations, or newspapers, newspaper and magazine circulation, etc.

Once our message has been designed, tested, produced, and placed on the air in conformity with our media strategy, then we have to design our tracking evaluations. The tracking of a mass media campaign can be done on a six-month basis in order to ascertain the extent to which we are achieving our objectives when compared to our baseline information. Tracking studies enable us not only to track the progress we are making but to learn from our experience and to revise our message design in the light of that experience to enhance the impact of our message on the target audience.

The question of message fatigue can only be answered by tracking studies. If our progress begins to flatten or to dip, then it may mean that our messages are losing their impact on our target audience. Or, it could mean that our media strategy needs reexamination. In either case, what is indicated is a complete re-evaluation of the total

program to ascertain which of the parts may require revision. New messages should be tested against old ones. Should new messages do better than the old ones on test, they ought to displace them.

The question as to how many messages are required for a radio campaign at any one time is not to be answered arbitrarily. This would depend on an analysis of how many different aspects of the problem suggest themselves as subjects. Adhering to the discipline that no more than one point--one aspect of a problem with its solution and its own motivation, etc.--should be incorporated into any one message, then the number of messages required would depend on how many aspects must be dealt with. Thus, it is not an arbitrary decision but an organic outgrowth of the analysis of the problem.

The key question in the use of mass media is the political question of access, which is re-emphasized at the close of this discussion because it is a consideration of such overriding importance. This is a public policy question which must be dealt with at the highest levels of government in order to win for nutrition education the greatest possible access to the use of the mass media for its essential messages.

(c) Community Training

Group Leaders: Lyra Srinivasan, Nonformal Education Consultant
Nancy Terreri, UNICEF - Indonesia

Recent years have seen significant methodological changes in nutrition education. One of the major innovations attempted by some international voluntary agencies is to reduce the reliance on purely didactic teaching methods and to adopt a learner-centered participatory strategy in their program design. Many factors have prompted this change. In particular, it reflects the belief that earlier didactic approaches have largely failed to create the kind of motivation and commitment to change which is needed at the community level in order to combat malnutrition in an effective and lasting way.

The experience of nonformal education and other components of integrated development programs confirms this view. The current stress, whether in health education or extension services, is on involving the target groups in defining their problems and working out solutions. In what special ways does the learner-centered approach function so as to increase people's motivation and commitment to action? There are several ways: for example, it shifts the responsibility for needs assessment from the hands of an outside authority figure to the hands of the people. At this point technical staff play a supportive role. The main aim is to engage the people in an open dialogue, using techniques which encourage them to look at their situation analytically without imposing an outsider's agenda on them. The fact that they have been genuinely involved in assessing their needs, problems, and resources is a tremendous boost to community morale. It is the first major step in creating community awareness of its own capacity for self-direction and initiative.

In addition, when the community itself is in charge, there is a freer expression of personal points of view and cultural biases which may or may not coincide with modern technical knowledge. The airing of taboos, misconceptions, and divergent ideas at this stage is invaluable. It helps both the community and the field worker to understand better the social, cultural, economic, and personality factors which can play an important role in reaching decisions. Technical staff can use this

knowledge to design new learning materials and experiences in such a way that the learning group fully confronts its own perceptions of local problems, and with the help of technical resources is able to recognize and deal with obsolete points of view. When the group as a whole is involved in examining traditional behavior and its consequences on the quality of life, the decisions to adopt new practices can be more binding on the members than when they are simply responding to prescriptive messages.

The relevance of the learner-centered approach to combating xerophthalmia is self-evident. The success of the program hinges on the role that the people are willing to play--the objectivity with which they themselves examine traditional feeding habits; the extent to which they are prepared to set aside cultural taboos; the mutual reinforcement they provide one another in decisions to adopt improved practices; the initiatives they commit themselves to take to detect and prevent blindness; their readiness to provide the main motivational power for the program and to follow up all action decisions with diligence. To achieve that high level of commitment, the field agency in turn must be prepared to utilize the most effective strategies currently known--and to design new ones if necessary--to initiate a process of empowering the people to act dynamically and responsibly in their own behalf.

The techniques used in the learner-centered approach are essentially simple. The initial difficulty lies in the attitude of field workers if they are used to a "telling" role. In that sense it is easier to lecture, to impart messages, and to instruct from a flip-chart rather than genuinely listen to and learn from the people. Training of the field worker is thus an important first step. The role which trainers play in such training must itself be consistent with the role they expect field staff to play in relation to clients. To use directive methods in training field workers and expect them to use participatory approaches effectively in working with the community is counterproductive. Trainees must experience the participatory style of learning and find it both enjoyable and growth-producing for themselves before they can be expected to utilize it with confidence and ease in their own work.

To facilitate the transition from didactic to learner-centered approaches, a number of simple, open-ended prototype materials have been designed by SARAR International, Inc., a voluntary non-profit agency based in New York; these materials and related participatory techniques have been utilized by Save the Children Federation in its nutrition education workshops in Indonesia and the Dominican Republic. A manual, based on the experience of Save the Children and other learner-centered groups, is currently being produced with assistance from INCS. The format is simple enough for local artists to reproduce in quantity after suitable adaptations to the local culture. A pre-planning meeting is held in which nutritionists and health educators from the country design and develop new methods and materials on participatory principles. Technical assistance is made available to them on a phasing-out basis. The responsibility for continuity thereafter becomes theirs.

Experience gained through the Save the Children Training Workshops indicates that a multi-sectoral approach is helpful in getting the local community fully involved in planning nutritional improvements. Joint training of field staff and supervisory personnel from different sectoral agencies also makes for a richer learning experience and increases the chances of collaboration in actual field situations. The added advantage is that a totally new delivery system does not have to be created to promote learner-centered nutrition education: an integral and cumulative effect is produced when the staff of different specialized service agencies all function from the same concern to maximize the people's involvement in program planning and implementation. They are also able to bring more varied feedback, from their separate perceptions, as to how the community members view their problems, needs, and potential; what cultural constraints and resources exist; and what are some priority messages from the people themselves which need to be heard.

Although HKI does not directly sponsor operational programs in the developing countries, it could be of great help in promoting a better understanding and use of learner-centered approaches as applied to Vitamin A deficiency programs in the following ways:

1. Developing a kit of prototype materials which demonstrates how the same theme or topic can be handled in a didactic or participatory way. National-level nutrition educators would thus have a clearer understanding of optional approaches and how to produce either type of material depending on their specific needs at any given time.

2. Organizing pre-planning meetings of technical staff in selected countries, to examine in detail the implications of the learner-centered approach in terms of educational activities design, materials development, delivery systems, and feedback.

3. Providing assistance in evaluation to agencies which utilize this approach, beginning with simple systems of baseline assessment and recording of progress.

4. Co-sponsoring training workshops at the country or subregional level on lines similar to those used by Save the Children.

(d) Evaluation

Group Leader: Dr. Richard Burke, Indiana University

The following are specific suggestions for technical functions which HKI could perform to assist developing countries in evaluating the effectiveness of nutrition education programs.

1. Assist in the selection of an appropriate model for evaluation

H. S. Bhola, in his monograph on Evaluating Functional Literacy, lists the following models for evaluation: CIPP, discrepancy evaluation, goal-free evaluation, transactional evaluation, evaluation as illumination, the advocacy model of evaluation, and participative evaluation. HKI should assist nutrition educators in developing countries to choose an evaluation model which takes into account the special aims of the program, the human and financial resources available, and the recognized constraints surrounding the project.

2. Assist in making the evaluation plan operational

Even with an appripriate evaluation model, nutrition educators cannot be expected to evaluate every phenomenon that occurs in a given intervention. HKI could help project planners in examining the inputs, processes, outputs, and context of their nutrition education program, in order to determine an appropriate and feasible hierarchy of evaluation needs.

3. Help to develop procedures for the formative evaluation and pre-testing of instructional materials

This would involve the preparation of guidelines for the selection of the pre-test audience, guidelines for the development of prototype materials, and assistance in preparing questions to be posed to the pre-test audience. In addition, HKI could assist nutrition educators by developing simple techniques for analyzing the results of pre-testing and incorporating these results into ongoing production efforts.

4. Assist in choosing appropriate indicators and measurement techniques for determining the level of knowledge gain and behavioral practices with respect to nutrition

HKI could help nutrition educators in the various countries

which have, or are planning to have, fairly large-scale mass media components in their programs to establish low-cost techniques for measuring the changes that take place with regard to dietary practices, infant feeding, and family food preparation.

5. Help to develop techniques for measuring the cost-effectiveness and cost-benefits of specific elements of the nutrition education program

This may be a bit ambitious, since the techniques for calculating cost-benefits can make heavy demands on people's time and energy, but it would certainly be important to know that the impact we are making is extremely expensive or, alternatively, that a particular education intervention is having a positive effect, at relatively low cost per person, per family, or per child.

HELEN KELLER INTERNATIONAL
COMMUNICATIONS WORKSHOP

August 1980

SMALL GROUPS

Session 1

A. Nutrition Education Planning

Gosselin
Griffiths
Khan
Kozusko
Mantra
Nager
Pettiss
Solon
Srinivasan
Toureau
Zeitlin

B. Evaluation

Andersen
Bagchi
Burke
Costello
Leone
Manoff
McKigney
Simmons
Sommer
Terreri

Session 2

C. Designing an Appropriate Mass Media Campaign

Andersen
Costello
Gosselin
Griffiths
Kozusko
Manoff
Mantra
Pettiss
Solon
Toureau
Zeitlin

D. Training and Community Level Materials Design

Bagchi
Burke
Khan
Leone
McKigney
Nager
Simmons
Sommer
Srinivasan
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Workshop for Helen Keller International (August 11-12,

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